Methods and Standards Governing Payment
for
Nursing Facility Services

CASE-MIX PAYMENT SYSTEM

Pennsylvania has established its Medical Assistance Long Term Care Program based on resident characteristics and the specialized service needs of the residents Nursing facility care is part of the long term care continuum, providing care to recipients whose medical needs do not require intensive hospital care, but need a higher level of care than that provided in a non-nursing facility setting. Effective January 1, 1996, the Department reimburses MA nursing facility providers under a prospective case-mix payment system.

The case-mix payment system has two major components: a system of resident classification and a system of price and rate setting. The case-mix payment system uses a comprehensive automated database, known as the Nursing Information System (NIS) to classify nursing facility residents and to determine nursing facility payment rates.

A. Resident Classification System

The first component of the case-mix payment system is the resident classification system. The case mix payment system uses the Resource Utilization Groups, Version III (RUG-III) nursing CMI scores to classify nursing facility residents. Nursing facilities submit individual resident assessment data, as reported on the Federally approved PA specific MDS, to the NIS database on electronic media via modem transmission as specified by the Department. Taking this data, the Department classifies each resident into the highest RUG-III value for which he qualifies, and calculates a quarterly MA case-mix index and an annual total facility case-mix index for each nursing facility. The Department uses these indices to determine annual peer group prices for each price setting period and to make quarterly rate adjustments for each rate setting period.

Nursing facilities shall maintain hard copy records for a minimum of four years following submission of the resident data. All nursing facility resident records are subject to periodic verification and audit by the Department.

B. Price and Rate Setting System

The second component of the case-mix payment system is the price and rate setting system. The Department calculates annual prices for each nursing facility peer group. In addition, the Department sets annual rates for each nursing facility. To calculate the annual peer group prices and individual nursing facility rates, the Department first uses the NIS database to select a database for the price setting period.

The database includes audited allowable costs. Allowable costs are defined and are identified in 55 Pa Code §§ 1187.2 and 1187.51 respectively.

1. The Database

a. Year one

For year one of implementation, January 1, 1996, through June 30, 1996, the database includes the most recent audited MA-11 cost report for each nursing facility that is issued by the Department on or before March 31, 1995, adjusted for inflation.

b. Year two

For year two of implementation, July 1, 1996, through June 30, 1997, the database will include the two most recent years audited MA-11 cost reports for each nursing facility that are issued by the Department on or before March 31, 1996, adjusted for inflation.

c. Subsequent fiscal periods

Beginning July 1, 1997 and each subsequent Commonwealth fiscal year thereafter, the database will include the three most recent years audited MA-11 cost reports for each nursing facility that are issued by the Department on or before March 31 of each July 1 price setting period, adjusted for inflation; provided, however, that if a nursing facility submits an acceptable cost report to the Department and the Department fails to audit the cost report within 15 months from the date of acceptance, the Department will include in the cost database the nursing facility's

reported costs, as adjusted to conform to Department regulations, for that unaudited cost report period until the audit has been completed.

d. Inflation Factor

The Department trends the cost in the database forward to the midpoint of the year for which the prices are being set using the most current available HCFA Nursing Home without Capital Market Basket Index, total index level, at the time price setting calculations are done.

2. Peer Grouping

After the Department selects the database for the price setting period, the Department classifies each participating nursing facility into one of 14 peer groups for net operating price setting. The Department classifies facilities that meet the Department's definition of hospital-based nursing facility and special rehabilitation facility into two separate statewide peer groups. To establish the twelve remaining peer groups, the Department uses the most recent MSA group classification, as published by the Federal Office of Management and Budget on or before April 1 of each price setting period, to classify each nursing facility into one of three MSA groups or one non-MSA group. The Department then uses the bed size of the nursing facility on the final day of the reporting period of the most recent audited MA-11 cost report in the NIS database to classify the nursing facilities into one of three bed size groups. These groups are 3 - 119 beds; 120 - 269 beds; and 270 beds and over. Except for the hospital-based nursing facility and the special rehabilitation facility peer groups, the Department will collapse a peer group with fewer than seven nursing facilities into the adjacent peer group with the same bed size. If there are two adjacent peer groups with which to merge, the peer group with fewer than seven nursing facilities will be collapsed into the peer group with the larger population MSA group.

3. Peer Group Price and Net Operating Rate Setting

Once the Department classifies nursing facilities into the appropriate peer groups, the Department then calculates the prices for each peer group. Under the case-mix payment system, nursing facility net operating costs are separated into three cost centers: resident care cost center, other resident related cost center and administrative cost center. The Department sets prices for each cost center and peer group on an

annual basis. After it sets the peer group prices, the Department uses the prices to calculate rates for the three net operating cost centers for each nursing facility.

a. Resident Care

To calculate the resident care cost medians and prices, the total resident care cost for each cost report is divided by the total facility CMI from the available February 1 picture date closest to the midpoint of the cost report period to obtain case-mix neutral total resident care cost for the cost report year. The Department divides the case-mix neutral audited allowable resident care costs for each cost report for each nursing facility by the nursing facility's total audited actual resident days for each cost report year to obtain each nursing facility's case-mix neutral resident care cost per diem for each cost report year.

For year two of implementation, the Department calculates the two-year arithmetic mean of the case-mix neutral resident care cost per diem for each nursing facility to obtain the average case-mix neutral resident care cost per diem of each nursing facility.

For all subsequent years, the Department calculates the three-year arithmetic mean of the case-mix neutral resident care cost per diem for each nursing facility to obtain the average case-mix neutral resident care cost per diem of each nursing facility.

The Department arrays the average resident care cost per diem for each nursing facility within the respective peer groups and determines a median for each peer group. The Department multiplies each median by a factor of 1.17 to determine the price for the peer group. The Department assigns that price to each nursing facility in the peer group.

The Department calculates each nursing facility's resident care rate by determining the lower of the nursing facility's resident care peer group price or 103% of the nursing facility's case-mixed neutralized resident care cost per diem plus 30% of the difference between the 103% calculation and the nursing facility peer group price. The Department then adjusts the rate each quarter by multiplying the rate by the nursing facility's MA case-mix index (CMI) to set the facility specific rate for resident care.

b. Other Resident Related

To calculate the other resident related cost medians and prices, the Department divides the audited allowable other resident related costs for each cost report for each nursing facility by the nursing facility's total audited actual resident days for each cost report year to obtain each nursing facility's other resident related cost per diem for each cost report year.

For year two of implementation, the Department calculates the two-year arithmetic mean of the other resident related cost for each nursing facility to obtain the average other resident related cost per diem of each nursing facility.

For all subsequent years, the Department calculates the three-year arithmetic mean of the other resident related cost for each nursing facility to obtain the average other resident related cost per diem of each nursing facility.

The Department arrays the average other resident related cost per diem for each nursing facility within the respective peer groups and determines a median for each peer group. The Department multiplies each median by a factor of 1.12 to determine the price for the peer group. The Department assigns that price to each nursing facility in the peer group.

The Department calculates each nursing facility's facility-specific other resident related rate by taking the lower of the nursing facility's resident related peer group price or 103% of the nursing facility's resident related cost per diem plus 30% of the difference between the 103% calculation and the nursing facility peer group price.

c. Administrative

The allowable administrative costs are determined so that all other allowable costs, excluding capital costs, equal no less than 88% of the allowable net operating costs. To calculate the administrative cost medians and prices, the Department adjusts, as appropriate, the total audited actual resident days for each nursing facility to a minimum 90%

occupancy. The Department then divides the audited allowable administrative costs for each cost report for each nursing facility by the total audited actual resident days, adjusted to 90% occupancy, if applicable, for each cost report year to obtain each nursing facility's administrative cost per diem for the cost report year.

For year two of implementation, the Department calculates the two-year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility.

For all subsequent years, the Department calculates the three-year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility.

The Department arrays the average administrative cost per diem for each nursing facility within the respective peer groups to determine a median for each peer group. The Department multiplies each median by a factor of 1.04 to determine the price for the peer group. The Department assigns that price to each nursing facility in the peer group.

A nursing facility's administrative rate equals its administrative peer group price.

d. Net Operating Rates

The Department determines each nursing facility's per diem net operating rate by adding the nursing facility's case-mix adjusted resident care rate, its other resident related rate and its administrative rate.

4. Capital Costs

Under the case-mix payment system, to determine each nursing facility's capital rate, the Department adjusts the latest nursing facility appraisal for the bed moratorium (See 55 Pa Code § 1187.113) and bed limitation for the applicable period. The bed limitation is the fixed property cost limited by the amount identified in § 1187.112 (relating to cost per bed limitation adjustment).

The movable equipment value is divided by the total number of beds to equal the cost per bed. This cost per bed is then multiplied by the beds

determined in accordance with 55 Pa Code § 1187.113 to obtain the appraised movable equipment value.

The calculation for the capital rate is as follows:

- The nursing facility appraisal value for land, building and land improvements are added together to determine the fixed appraisal value.

- If the nursing facility has a Certificate of Need cost overrun. The overrun percent is subtracted from one (1.00) and the result is multiplied by the appraisal value of the categories specific to the nursing facility.

- The allowable beds (per § 1187.113 (relating to capital component payment limitation)) are multiplied by $22,000 or $26,000 (based on the time frames specified in § 1187.112 (relating to cost per bed payment limitation) to determine the bed limitation amount.

- The bed limitation amount or the fixed appraisal value, whichever is lower, is selected to determine the fixed bed limited value.

- The allowable beds are divided by nursing facility certified beds as of April 1 of the rate setting period to determine the bed moratorium percent and this percent is multiplied by the movable equipment amount to determine the movable after moratorium value.

- The movable after moratorium value is added to the fixed bed limited value to determine the total appraisal amount.

- The total appraisal amount is multiplied by the financial yield rate to determine the fair rental value.

- The audited real estate taxes are added to the fair rental value and this amount is divided by the greater of the audited nursing facility actual resident days or the nursing facility available days at 90% occupancy to determine the capital rate. The source of resident actual and available days for new/prospective providers is the most recent available cost report.

The Department will make capital component payments for nursing facility beds constructed, licensed or certified after November 29, 1997 if the Department approves those beds as replacement beds in accordance with Chapter 1187, § 1187.113a(c)-(e).

The Department will grant waivers of § 1187.113(a) to permit capital cost reimbursement as the Department in its sole discretion determines necessary and appropriate. The criteria the Department will use to evaluate and approve applications for capital cost reimbursement waivers is contained in § 1187.113b. Waivers of the moratorium regulations granted to nursing facilities under 55 Pa. Code Chapter 1181 remain valid, subject to the same terms and conditions under which they were granted, under the successor regulations set forth at 55 Pa. Code § 1187.113(a). Waivers of § 1187.113(a) will not otherwise be granted except as provided under § 1187.113b.

Real estate taxes or reasonable payment made in lieu of real estate taxes are paid under the case-mix payment system on the basis of actual costs as audited on the most recent audited cost report in the database used for price setting.

5. Case-Mix Per Diem Rate

A nursing facility's case-mix per diem rate for an MA resident day is the sum of the nursing facility's net operating rate and its capital rate. The Department calculates payment rates on a quarterly basis. Rates are set for nursing facilities with a change of ownership, new nursing facilities and reorganized nursing facilities as specified in § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) of the state regulations.

C. Cost Finding

All nursing facilities participating in the Medical Assistance Program shall use the direct allocation method of cost finding. Under this method of cost finding, costs are apportioned directly to the nursing facility and residential or other facility based on the appropriate financial and statistical data.

D. Cost Reporting and Audit Requirements

All nursing facilities participating in the MA Program shall report allowable costs and the results of the cost finding process on forms specified by the Department. Allowable costs are classified in four cost centers: resident care; other resident related; administrative and capital. Net operating costs include resident care, other resident related and administrative. All records are subject to verification and audit. The financial and statistical records of all nursing facilities are audited periodically by either the Department or the Auditor General.

In addition, for the purpose of determining nursing facilities' allowable capital costs, each nursing facility is appraised by the Department. Reappraisals will be completed at least every five years. Limited appraisals will be conducted when a nursing facility makes additions or deletions to capital of more than $200,000 or 10% of the appraisal value, whichever is lower.

A nursing facility shall hold, safeguard and account for residents' personal funds upon written authorization from the resident in accordance with all applicable provisions of state and federal law. The Department periodically audits residents' personal fund accounts.

E. Allowable Program Costs and Policies

Allowable costs are those costs which are necessary and reasonable for an efficiently and economically operated nursing facility to provide services to MA residents. Allowable costs are identified in and subject to limitations specified in Subchapter H (relating to Payment Conditions, Limitations and Adjustments) of the state regulations, including the prudent payment principle. Only the direct and indirect costs related to resident care are allowable. Any costs of materials or services covered by payments made directly to providers, other than nursing facility services under Medicaid and Medicare or other insurers and third parties, are not allowable.

All nursing facilities participating in the MA Program must allocate costs between nursing facility services and non-nursing facility services in accordance with the allocation bases established or approved by the Department.

F. Hospice Services

If an MA recipient residing in a nursing facility is dually eligible for Medicare Part A services and elects to receive hospice services in lieu of nursing facility services, as applicable, the MA Program pays a Medicare-certified hospice provider an amount equal to the room and board payment made to the nursing facility as part of the nursing facility services and will discontinue direct payment to the nursing facility for services. The hospice provider, in order to receive payment from the Department, shall enter into an agreement with the nursing facility by which the hospice provider agrees to assume full responsibility for the recipient's hospice care and the nursing facility agrees to provide room and board to the recipient. (See Attachment 4.19B, Item #21)